

WRMA

Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

SERVICE AREA 2 FOCUS GROUPS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

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I. Introduction

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key stakeholder interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

The California Department of Mental Health (CDMH) has defined *mental health prevention* as reducing risk factors or stressors, building protective factors and skills, and increasing support to allow individuals to function well in challenging circumstances. Whereas, *mental health early intervention* involves a short duration (usually less than one year) and relatively low-intensity intervention to measurably improve a mental health problem or concern early in its manifestation and avoid the need for more extensive mental health treatment or services later.

In addition, CDMH has targeted five community mental health needs, six priority populations, and six statewide efforts for the PEI Program, and has identified seven sectors that counties must partner with to develop their PEI Plan.

This report presents the findings from the Focus Groups conducted in Service Area 2. Each service area will receive a report of the findings specific to the focus groups selected to speak on its behalf. In addition, a comprehensive final report will be produced presenting aggregate findings across all of the focus groups conducted in Los Angeles County.

II. Methodology

Participants

Each focus group was comprised of no more than 10 participants. Participants were drawn from existing groups/organizations for the purpose of participating in a discussion about the mental health service needs, barriers, and strategies in their respective communities.

- As with the Key Individual Interviews, the focus groups were selected based on Service Area representation and the categories of MHSA age group, sector, priority population, and key community mental health needs for PEI. Utilizing recommendations made from LACDMH District Chiefs, Service Area Advisory Committee (SAAC) members, and other stakeholders throughout the county familiar with the categories, LACDMH selected focus groups that qualified in at least two PEI categories.
- LACDMH identified a focus group coordinator from each community group/organization selected. The focus group coordinator sought participation in the focus group from among the organization's membership. Focus group coordinators were asked to identify and invite a diverse group of participants who could speak about service needs, barriers, and recommended strategies for their Service Area.
- A total of 44 individuals from the following six organizations in Service Area 2 were asked to participate in their respective focus group:

1. Armenian Relief Society Center;
 2. Glendale Clients Helping Clients;
 3. Promotoras de Salud Para la Comunidad;
 4. San Fernando Coalition on Gangs;
 5. San Fernando/Santa Clarita Child Abuse Prevention Council; and,
 6. Valley Care Consortium Committee (VCCC), Mental Health Subcommittee.
- Five of the six participating agencies from which the focus groups were drawn have been in existence between five and 25 years, and support between 4 and 1,500 members. The sixth participating agency, the Armenian Relief Society, is represented worldwide, supports 18,000 members, and has been in existence almost 100 years.
 - Across the six participating agencies, members range in age from 16 to over 60, with one participating agency representing 26 to 59 years old only.
 - The ethnic composition of the six participating agencies is diverse. The Latino/Hispanic community is represented in five of the six participating agencies. Caucasian and Middle Eastern communities are represented in four of the six agencies, with the Armenian community represented in three agencies, the Farsi community by two agencies, and the Russian community by one agency. African Americans and Asian Pacific Islanders are also represented in of the six agencies and American Indians in two.
 - Finally, the six participating agencies represent the following community sectors in Service Area 2: Health, Individuals with Serious Mental Illness, Mental Health Service Providers, Social Services, and Law Enforcement.

Procedures

Each focus group coordinator worked closely with a member of the contracted consulting team to arrange focus group dates, times, and locations.

The focus groups were conducted at the organizations or agencies representing the focus group participants or other community-based locations. The focus groups were audio recorded and took about two hours to complete. Nine key questions, some of which contained sub-questions, were posed to focus group participants. The questions were designed to produce information needed to inform the PEI planning process. A copy of the Focus Group Guide can be found in **Appendix A**.

Facilitators representing LACDMH at the focus groups as a neutral third party included a team of three staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc. and Laura Valles and Associates, LLC. One team member facilitated the focus group, another observed and documented notes, and a third recorded participants' responses on flip charts, which participants could refer to throughout the focus group.

Focus group documentation included: a Focus Group Profile, a Focus Group Participant Profile, a signed Consent Form indicating that the focus group would be audio recorded, the observer's electronic notes, the paraphrased responses from participants, an audio recording of the focus group, and a transcript of the focus group developed from the audio recording. A report was written by the focus group team observer, summarizing the group's responses to the questions. Information from each focus group was coded so that the data could be analyzed and presented in summary format.

III. Knowledge of the PEI Planning Process

Participant Participation in the PEI Planning Process (Q1)

The first question(s) that focus group participants were asked to answer was “Have you or your group taken part in the Los Angeles County Department of Mental Health’s PEI planning process? And, if so, how?” Of the 44 focus group participants, 20 members from five of the six focus groups had participated in the PEI planning process in different ways: 1) some attended SAAC Meetings; 2) others attended PEI Stakeholder meetings; 3) a few attended various informational meetings about PEI at the local school district or at other agencies; and, 4) a number attended any combination of the three previously listed forms of participation. One participant has been involved in the PEI process via the District Chief of Department of Children and Family Services (DCFS). None of the Promotoras de Salud Para la Comunidad focus group participants had participated in the PEI process.

IV. Service Area and Priority Population Representation

Service Area (Q2)

When focus group participants were asked which service area they represented, 36 of 44 participants indicated Service Area 2; four participants represent Service Area 4; three participants represent Service Areas 4 and 5; and one represents Service Area 7. Eleven participants have Countywide representation. Eight participants from one group indicated that they predominantly represent Service Area 2, but simultaneously represent Service Areas 1, 3, 4, 5, and 8 in one way or another.

Priority Populations (Q2a)

The CDMH has identified the following six priority populations for PEI services: 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children and youth in stressed families; 4) Trauma-exposed individuals; 5) Children at risk for school failure; and, 6) Children and youth at risk of or experiencing juvenile justice involvement. Focus group participants were asked to select the priority populations they represent. As shown in **Table 1**, of the six priority populations, over 75 percent of participants represent Trauma-exposed individuals and/or Underserved cultural populations. Between 66 and 70 percent of participants represent Children at-risk of school failure, Children and youth in stressed families, and Children and youth at-risk of or experiencing juvenile justice involvement. A little more than half of the participants indicated that they represented Individuals experiencing the onset of serious psychiatric illness.

Table 1: PEI Priority Populations

PEI Priority Populations	Number of Participants	Percent of Participants (n=44)
Trauma-exposed individuals	35	80%
Underserved cultural populations	34	77%
Children at risk of school failure	31	70%
Children/youth in stressed families	30	68%
Children/youth at-risk of or experiencing juvenile justice involvement	29	66%
Individuals experiencing the onset of serious psychiatric illness	24	55%

V. Community Mental Health Needs and Impacts

Mental Health Needs in the Community (Q3 and Q3a)

Each focus group participant identified the mental health needs in their community based on five MHSA categories: 1) Disparities in access to mental health services; 2) Psycho-social impact of trauma; 3) At-risk children, youth, and young adult populations; 4) Stigma and discrimination; and, 5) Suicide risk. Of the six focus groups representing Service Area 2, four indicated which mental health needs exist in their communities. The two focus groups whose participants did not individually identify mental health needs, instead identified the top three mental health needs in their communities.

Of these five needs, 83 percent of 29 participants from four focus groups indicated that Stigma and discrimination is a predominant mental health need in the communities they serve (see **Table 2**). Stigma and discrimination was followed by At-risk children, youth, and young adult populations (79%), Disparities in access to mental health services (79%), Psycho-social impact of trauma (76%), and Suicide risk (66%).

Table 2: PEI Mental Health Needs

PEI Mental Health Need	Number of Participants	Percent of Participants (n=29*)
Stigma and discrimination	24	83%
At-risk children, youth, and young adult populations	23	79%
Disparities in access to mental health services	23	79%
Psycho-social impact of trauma	22	76%
Suicide risk	19	66%

*Participants from two focus groups did not indicate which mental health needs exist in their community.

When asked to identify the top three mental health needs from among the list of five determined by CDMH, all six focus groups identified Disparities in access to mental health services as the top need (see **Table 3**). Receiving equal weight, At-risk children, youth, and young adult populations, Psycho-social impact of trauma, and Stigma and discrimination were the second highest needs selected by the six focus groups. Due to the three-way tie for the second priority, a third priority did not emerge from the aggregated priority selections across focus groups.

Table 3: Priority PEI Mental Health Needs

Priority PEI Mental Health Needs	Number of Groups (n=6)	Priority
Disparities in access to mental health services	6	1
At-risk children, youth, and young adult populations	4	2
Psycho-social impact of trauma	4	2
Stigma and discrimination	4	2

Impact of the Mental Health Needs on the Community (Q4)

As presented in **Table 4**, focus group participants reflected upon and relayed the negative impact that unmet mental health needs have had on their communities. The three most highly mentioned impacts were a range of concerns about service access, increased levels of community and family violence, and the mental health issues affecting community members.

With respect to access, participants were most concerned about the lack of prevention and early intervention services across age groups that would meet the needs of foster care youth who graduate out of foster care, treat substance abuse and suicide risk, and address immediate needs before they become exacerbated and require higher levels of care. A couple of participants also noted the lack of access to counseling services such as anger management, support services for immigrants and youth, and low-cost services. The lack of culturally competent and linguistically appropriate services were also mentioned, as were the stigma associated with mental health and the palpable discrimination toward people with mental illness.

“People don’t have access to mental health care. The services like anger management, domestic violence type services aren’t out there in the communities as they need to be. Parenting-type programs need to be out there ... if you had access to these kinds of services, you would definitely start seeing a decrease in some of the violence that we’re having in our communities.”

Community and family violence and abuse emerged as another outcome of unmet mental health needs. Focus group participants cited a host of issues in this area including youth crimes, homicides, gang violence, juvenile justice involvement, and self-injury, especially among females. Participants also pointed out the rise in cases of child neglect and physical and sexual abuse, including children-on-children abuse, as well as the identification of multigenerational cycles of familial abuse and trauma.

“Because of the homelessness, there is more crime.”

The rise in mental health issues was also mentioned consistently with participants raising concerns about the increase in drug and alcohol abuse among broken families and among youth in gangs. One participant was concerned about the high suicide rates among youth and

the elderly due to lack of information regarding mental health services and lack of access to counseling and psychologists. Depression as a result of substance abuse was also noted. In addition, one participant pointed out that high stress levels and lack of access to services have resulted in a higher number of strokes.

In addition to service access, community and family violence and abuse, and mental health issues, focus group participants discussed the increasingly poor social conditions of communities as evidenced by increases in crime, prostitution, and poverty. These conditions contribute to the communities’ failing infrastructure and lead to the further collapse of communities and the families within those communities. More specifically, participants reported seeing more and more evidence of broken families unable to provide support to their children, family crises that go unresolved, unavailable and disengaged parents, rising stress levels among family members, and cultural tensions between generations in immigrant families, in particular.

“The children grow up in this country and the parents come from the old country...and in this country they [parents and kids] see things different. The parents come from another country with different traditions, different rules and different ways of thinking...”

Other impacts mentioned that did not fit into any specific category but worth noting are:

- High caseloads which result in overburdened clinicians with less time to engage clients and develop rapport, thereby, reducing the effectiveness and quality of the service;
- Increased victimization among families that are over-stressed; and,
- Increase in teen pregnancies, potentially resulting from the SB 500 provision permitting foster parents who have requisite certification to care for pregnant teens.

**Table 4: Ways in which Mental Health Needs
Impact the Community**

Community Impact	Number of Mentions
Access Issues	17
• Available Services/Capacity	7
• Service Linguistic/Cultural Competency	3
• General Service Access	2
• Stigma and Discrimination	2
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1
• Transportation	1
• Service Operations	1
Community/Family Violence/Abuse	10
Mental Health Issues	9
• Substance Abuse	4
• Depression/Suicide Risk	3
• Specific Mental Health Issues	3
• Trauma/PTSD/Anxiety	1
Social/Economic Conditions	6
Community/Family Breakdown/Hopelessness	5
Families/Parent High Stress Levels/Parenting Issues/Poor Social Skills/Coping	5
Academic Outcomes	2
Collaboration/Partnerships/Teams	2
Funding and Resources	2
Immigration/Cultural Matters	2
Service Engagement/Benefits	2
Service Integration/Continuity of Care	2
Unaddressed/Exacerbated Mental Health Conditions/Higher levels of Care/ Poor Outcomes	2
Generational Cycle	1
Juvenile Justice Involvement/Incarceration	1
Medication Issues/Management	1
Negative/Risky Behaviors	1
Child Welfare/Foster Care	1
Specific Services	1
Other	5

VI. Existing and Needed Prevention Services/Resources

Existing Prevention Services/Resources (Q5)

The following is a listing of all the existing prevention services identified by participants across all six focus groups. It should be noted that two of the six focus groups struggled to identify existing prevention services for their communities. In two other groups, observers noted that the number of prevention services was limited.

- Boys & Girls Club.
- CalWorks Program, offers single parents the ability to attend school and/or receive workforce development training. The program provides childcare and other supports.
- Canoga Park Schools, particularly Lawrence and Columbus middle schools which provide parenting classes on building better social and emotional relationships with children.
- Canoga Park Youth Arts Center.
- DCFS Child Abuse Prevention and Intervention Treatment (CAPIT), at Valley Trauma.
- Department of Public Social Services (DPSS) and DMH partnerships, which offer free child care for families who have been assessed, providing a way to monitor whether or not child abuse is occurring in the home.
- El Proyecto de Amistad, a learning center with tutors and computers to help kids increase their literacy levels by the 5th grade.
- Family Childcare and Home Care Education Network.
- Family Support Services, at Friends of the Family and Valley Trauma.
- First 5 School Readiness Initiative.
- Forty Developmental Assets Program, developed by the Search Institute and designed to help youth build assets.
- Glendale YWCA:
 - Teen Dating Violence Prevention Program;
 - 24-hour Hotline; and,
 - Other services for children of battered women.
- Grandparents as Parents, a program funded by a private foundation.
- City of Los Angeles funded family development network grants in the northeast valley.
- Keep Youth Doing Something (KYDS), focuses on pregnancy, drugs, delinquency and other prevention-related efforts.
- LA Best Babies Network, provides prenatal education, health care and mental health services.
- LA City Attorney's Office "No Secrets" program, a truancy and child abuse prevention program.
- LA County Probation program, activities to prevent at-risk youth from advancing into the criminal justice system:
 - Clinical therapists work with ADHD kids; and,
 - Individual case management.
- Law Enforcement Programs, offering home work assistance, one-on-one tutoring, mentoring, recreation, sports, socialization, field trips, volunteering, and family case management such as:
 - Police Activities League (PAL);
 - Jeopardy; and,
 - Explorers.
- DPSS/DCFS Partnership, provides linkages to prevention services for high risk families.
- Local athletic and church groups for kids.
- Mission Community College:

- Family Development Network, provides mental health services, addresses relationships between parents and children, and offers drug and alcohol abuse counseling.
- New Directions for Youth, offers tutoring and mentoring.
- Northeast Valley Health Center, provides social workers and counseling services.
- Parent Centers at preschools, offer educational and support services.
- Points of Engagement, flags cases for specialized prevention social workers.
- Primary Intervention Program (PIP), trains parents to communicate with children and school personnel.
- Probation Camps.
- Programs for teenage parents.
- Project Safe, a substance abuse prevention program.
- Providence Holy Cross, offers mental health and other services.
- School-based Programs:
 - Curriculum-based programs;
 - Grief support groups;
 - On-site counseling for at-risk students;
 - Parenting skills programs; and,
 - Social skills programs for anti-bullying.
- Second Step, an evidence-based violence prevention program.
- Verdugo Mental Health:
 - Chat support groups;
 - Drop-in services; and,
 - Individual, couple, and family counseling outpatient services; and,
 - Psychiatrist conducts community outreach in diverse settings such as public parks.
- Weekly radio show with two psychiatrists that educate the public about social and emotional issues.
- YMCA.

Needed Prevention Services/Resources (Q5a)

All six focus groups identified a number of needed prevention services and/or resources as reflected by the list below. The needed prevention services are organized by type of service/resource and listed from highest to lowest number of needed services/resources cited under each service/resource type.

Specific Services and Resources

- Child abuse prevention training for mandated reporters and parents (i.e., parents need to recognize the signs of child abuse, and be able to supervise their children when they are with friends and family).
- Culturally based programs that support Armenian children with special needs.
- Youth involvement opportunities such as mentoring programs, which currently exist in a limited capacity.
- More services for pregnant teens and single mothers.
- Seniors services, such as mental health education and social events, as well as an information delivery system that is appropriate for their age.
- Homeless support services such as shelters and food banks.

“It is important for the Department to take a holistic approach to mental health services because people experience problems on a physical, spiritual, and emotional level -- and when they are off balance is when they have issues.”

- Health promotion programs that connect physical, mental, and spiritual health, especially for the Latino community. An example of this kind of approach is diabetes care, which has both a physical and emotional dimension.
- Services in community health care clinics where needs can be identified.
- Mobile services, especially for kids not accessed through traditional settings (i.e., schools vs. homeless shelters).
- More community centers with a one-stop approach providing a full range of services.
- More recreational, artistic, and after-school programs that provide safe places with sensitive counselors with whom teens can talk; with special attention paid to summer activities such as camp.
- More school based programs that would be offered before and after school, provide transportation to families as needed, train parents to run groups and be resources, and tap into the resources in the existing community populations.
- More long-term (beyond 10-weeks) counseling services that can be billed to contracts.
- Anger management, conflict resolution, and parenting skills building programs for all populations.
- Transitional and after care services following probation camps.
- Parenting classes in a variety of languages.

Specific Strategies and Approaches to Service Provision

- DCFS and other agencies need to have a listing of available resources (DCFS had started a resource listing with Team Decision Making, but it is not currently available). It was suggested that this might be a collaborative project between DMH, DCFS, DPSS, and CBOs.
- Increased resource sharing within DCFS.
- Effective networks to remind providers, including DCFS staff, who and how to refer community members to community services and resources.
- More cross-collaborative support and follow through with referrals so that reported suspected cases of child abuse do not fall through the cracks.
- More effective linkages to services; specifically, better transfer of information or referrals between DCFS, Probation, and DMH.

“I think [what] we need is some sort of network for all agencies to remind each other of what services are available. Let me give you an example. I got parents or foster parents, any number of parents, calling that ... have open cases with DCFS, and they're looking for some sort of mental health service, so we refer them out because we happen to be a child care agency. They have asked us many times about childcare. Well, most workers unfortunately don't know that they have [in] their own pot of money at DCFS to help families who have an open case with DCFS to pay for child care. So we tell them all about the program, and who to contact. And then they call their worker. And their worker says, ‘Nope. That's not there.’ So this is just one of the -- let's say, struggles that we have because what ends up happening is at the end of the year, DCFS has ... leftover [funding] and they don't know what to do with it. They have to find a project for this pool of money because people don't know that the services are available to them.”

- Prevention strategies following a family trauma such as sexual abuse or domestic violence.
- Expansion of the Team Decision Making (TDM) system. For example, utilize the concept universally, and pay providers that attend TDMs so that it is possible for them to participate regularly.
- Ability to provide and bill for non-clinical programmatic strategies, such as anger management and conflict resolution groups.

Outreach, Education, and Awareness Services and Resources

- Increased awareness of existing services/resources available to clients.
- Public awareness campaigns that de-stigmatize the issue of mental health and well being.
- Education about the relationship between physical health issues and mental and spiritual health.
- Education and awareness for parents and teachers on identifying and managing mental health issues.
- Education and training to community and foster parents on how to identify signs and symptoms of mental illness, and other problematic behaviors, such as gang involvement.
- Parent education on how to manage one's emotions, in general, as well as how to help children manage their emotions.
- Education on sexuality, STD's, and chronic illness, as a means of addressing the high rate of young teen girls who are sexually active and become pregnant or are exposed to STDs.
- Education services on domestic violence.
- Education on preventing alcohol and drug abuse.

Services and Resources that Increase Access

- Free or affordable services for people lacking medical insurance or ability to pay.
- Free, low cost, subsidized youth activities that do not stigmatize participants and foster community participation.
- Linguistic and culturally competent Armenian speaking providers.
- Services provided in a holistic approach that are culturally and linguistically appropriate.

Funding and Resources

- Additional funding and expansion of effective programs such as Glendale Clients Helping Clients or other peer support programs.
- Adequate funding for innovative practices, such as Title IV-E waiver, which brings people to the table, but does not have enough funding to sustain everyone involved.
- Funding for programs that can treat the parents as well as the children, as in a comprehensive family support system.

Service Collaboration, Partnerships, Teams

- Greater cooperation/collaboration between schools and community based providers.
- Increased collaboration among community based organizations.

Provider and Staff Education, Training, and Recruitment

- Training new DCFS social workers on how to access community resources. Social workers are overwhelmed with large case loads and find it extremely challenging to research and provide adequate referrals to available resources.
- Provider and staff trainings need to be culturally relevant.

Services that are Integrated and Provide Coordinated and Transitional Care

- Increased communication and integration among County departments, CBOs, and prevention initiatives.
- More efficiency in integrated services along with better customer care that is sensitive to client issues.

System Support, Assistance, and Navigation Services

- Services that help people navigate the system.

“I wanna say there’s like zero communication between our department [DCFS] and the Department of Mental Health. I mean there’s just ... there’s no sharing of information. It’s not a partnership. They’re separate entities, and it [causes] serious problems ‘cause the goals are the same but we’re banging heads.”

Priority Prevention Services/Resources (Q5b)

When four of the six focus group were asked to prioritize the needed prevention services they had listed in response to the prior question, they selected three priority services, as presented in **Table 5**. Two of the six focus groups represented pilot sites and were not asked by the focus group facilitators to prioritize prevention services.

The priorities identified by four of the six groups asked to prioritize reflected prevention services that would:

- Increase awareness of non-stigmatizing services and non-stigmatizing ways to obtain resources/services;
- Train service providers and others about culturally and linguistically appropriate service provision;
- Develop family-centered services that view families holistically;
- Promote partnerships with schools;
- Conduct social networking in communities;
- Introduce mobile services; and,
- Expand peer-to-peer services, youth groups, and parent education.

Additional priorities listed by one of the focus groups were: 1) better services through greater access, integration and collaboration with other services, and better customer service; and, 2) long-term support for families, such as anger management and conflict resolution, using non-traditional approaches. Please note that these priorities are not listed in rank order.

Table 5: Priority Prevention Services/Resources (n=4)

Focus Group	Priority 1	Priority 2	Priority 3
Armenian Relief Society	Providers, resources, and programs that are culturally and linguistically appropriate.	Media outreach, public awareness, and de-stigmatization that include online or hotline resources that allow anonymity.	Youth groups with positive role models and mentorship opportunities.
Glendale Clients Helping Clients	More peer-to-peer services similar to Glendale Clients Helping Clients.	Second priority not provided.	Third priority not provided.
San Fernando Coalition on Gangs	Mental health awareness and cultural competency training for parents, teachers, mental health providers, and mandated mental health reporters.	Stronger partnerships and collaboration between schools and mental health service providers.	Mobile services.
San Fernando/Santa Clarita Child Abuse Prevention Council	Family-centered services that view families holistically.	Expanded education, awareness, and networking among all partners.	Utilization of a preventative community engagement strategy, including the promotion of social networking, team decision making, and parent education.

Note: Priorities not listed in rank order

Locations for Prevention Services/Resources (Q5c)

Table 6 presents the locations at which focus groups would like to see prevention services offered. All three focus groups responding to this question suggested locating prevention services at churches or synagogues, community centers, hospitals, libraries, parks and recreation centers, and schools. Other locations offered by the three participating focus groups can be found in the table below.

Table 6: Prevention Service Locations

Prevention Service Locations	Number of Groups (n=3)*
Churches/Synagogues	2
Community Centers	2
Hospitals	2
Libraries	2
Parks and Recreation Centers	2
Schools	2
Agencies that have Promotoras	1
Boys and Girls Clubs	1
Community Health Clinics	1
Factories	1
Homeless Shelters	1
Homes	1
Laundromats	1
Primary Care Physician Offices	1
Probation Camps	1
Restaurants	1
Substance Abuse Programs	1
Supermarkets	1
Work Sites	1

*Three focus groups did not provide preferred locations for prevention services

VII. Existing and Needed Early Intervention Services

Existing Early Intervention Services/Resources (Q6)

The following is a listing of all the existing early intervention services identified by the participants across the six focus groups. Among the six focus groups, three had difficulty either identifying early intervention services or differentiating early intervention services from the prevention services cited earlier. One group felt that the same services identified for prevention could also be considered early intervention services.

“Prevention and early intervention are all intertwined ... because bringing education to the parents may be prevention, but it may be an early intervention to their child.”

- Armenian Relief Society, offers programs for recent immigrants.
- Armenian Youth Federation, employs and trains youth advisers to recognize warning signs of alcohol abuse.
- Boys and Girls Club.
- Community organizing events and fairs that promote community bonding and cohesion such as women’s group, fraternities, and extended families.
- Back in Control, a parenting educational program.
- Boot Camps, for at-risk kids already involved in anti-social or criminal behavior.
- Canoga Park Youth Arts Center.
- Catholic Charities.
- CBITS, an evidenced-based trauma program.
- Child Abuse Prevention, Intervention, and Treatment (CAPIT).
- Childcare Services.
- Children’s Services at Verdugo Mental Health.

- Community Based Organizations:
 - YMCA;
 - Boys and Girls Club;
 - Valley Trauma; and,
 - Childcare Resource Center.
- DAPEC, a drug education program in schools with local agency collaboration
- Drug and Alcohol programs.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Effective Adolescent Treatment (EAT) Program, uses a five session model to address early substance abuse.
- El Nido Family Resource Center.
- El Proyecto de Amistad, a learning center with tutors and computers to help kids increase their literacy levels by the 5th grade.
- Evidenced Based Counseling Techniques, such as functional family therapy and multi-systemic therapy.
- Faith-based Organizations.
- Family Preservation and Family Support.
- Glendale Clients Helping Clients, an early intervention service that provides support and education at a peer-to-peer level. This program allows clients to relate to each other and receive mutual support throughout their recovery process.
- Grandparents as Parents.
- Inpatient and Outpatient Facilities at Verdugo Mental Health.
- Keep Youth Doing Something (KYDS), pregnancy, drugs, delinquency and other prevention-related efforts.
- LA City Attorney's Office "No Secrets" Program, focuses on truancy and child abuse prevention.
- LA County Probation Program, offers activities to prevent at-risk youth from advancing into the criminal justice system, clinical therapists to work with kids experiencing ADHD, and individual case management.
- Law Enforcement Youth Programs that offer home work assistance, one-on-one tutoring, mentoring, recreation, sports, socialization, field trips, volunteering, and family case management:
 - Police Activities League (PAL);
 - Jeopardy; and,
 - Explorers.
- Linkages Program between DCFS and DPSS.
- Los Angeles County Sheriff's VIDA Program (Vital Intervention and Directional Alternatives).
- Mandated Reporters, other than the Department of Children and Family Services (DCFS), teachers, and law enforcement officers, such as Society for Prevention of Cruelty to Animals, photo technicians, among others.
- Mental Health Component of Head Start, DMH assists Head Start when they need assistance with a case for a short period of time until child is referred to a waiting list.
- New Directions for Youth offers tutoring and mentoring.
- Points of Engagement (POE).
- Probation Camp Programs, collaborate with the courts to provide mental health screenings and services.

"We have a greater support system because of multi-generational family structures. We meddle in each other's lives and we feel free to tell the parents of our kids when they're acting up!"

- Programs that help people navigate the system.
- Promotora Network, an effective resource that works with families to prevent and or lessen the impact of certain illnesses such as obesity and chronic illness through the dissemination of information at fairs where they can intervene and detect health issues early.
- Psychiatric and medication services that prevent symptoms from worsening.
- Regional Centers.
- School-based programs with on-site counseling and mental health services.
- STEPP, an evidenced based program for effective parenting.
- Team Decision Making (TDM).
- Universal Preschools.
- Valley and Treatment Center.
- Voluntary Family Maintenance.
- YMCA.
- YWCA, in particular, the outreach services to local high schools twice a year during sexual assault and domestic violence awareness months that educate women on how to recognize signs of dating violence, and how to prevent it.

Needed Early Intervention Services/Resources (Q6a)

All six focus groups identified a number of needed early intervention services and/or resources as reflected by the list below. The needed early intervention services are organized by type of service/resource and listed from the highest to the lowest number of needed services/resources cited under each service/resource type.

Specific Services and Resources

- Comprehensive mental health services.
- Services provided at all levels, such as individual, group, family, and couples therapy.
- Services for 18-24 year olds.
- Youth-centered services, especially at family resource centers and parks and recreation centers.
- Kinship support center in the Valley.
- Specialized Psychiatric Evaluation Teams (PET) for children.
- More emergency psychiatric care facilities for children and adolescents, as well as increased availability of Psychiatric Evaluation Teams (PET).
- Multi-disciplinary service models which allow providers to share information on effective case management.
- A structured early detection test or questionnaire that will help people identify any mental health risk factors they or their children might have. The early detection tests for Alzheimer's and diabetes can serve as models.

Services and Resources that Increase Access

- Programs and services that reduce stigma.
- Programs that reduce stigma, ostracism, shame and discrimination for LGBTQ youth.
- Programs that reduce stigma, ostracism, shame and discrimination of special education children.
- Increased low-cost and no-cost inpatient and outpatient services for low-income people who lack insurance.
- More low costs services and programs.

“We need programs for the Armenian parents to [deal with the issue] and how to support and accept [LGBTQ youth] ... because there is very little dialogue and even if the parents are accepting, the extended community may not be.”

- Services that provide access to family counseling at no cost.
- Transportation and mobile services.
- Increased services for Armenian programs.
- Culturally appropriate services, especially since therapists play such important roles in families.
- Services that are provided in the appropriate language of participants.

Location-based Services

- Community based programs that would provide treatment for and collaborate with families, using parents as a resource.
- Services at probation facilities.
- Services at medical offices.
- School-based services in general.
- Expansion of school-based services that are on-site, curriculum-based, and fit with families' schedules.
- Services in schools, including individual and family counseling, and education for anger management, anti-bullying, grief, coping, parenting, dealing with divorce and trauma, gang prevention, and suicide prevention.
- Services accessible to community members by means of public transportation or within walking distance, as many people do not have transportation and walk to a nearby provider.
- Services that are provided in people's communities and neighborhoods.

Outreach, Education, and Awareness Services and Resources

- Public education through mass media outlets with a calendar of shows and events.
- Public service announcements (PSAs) in Armenian languages.
- Greater awareness of good services that exist in even the American, non-Armenian community.
- Outreach and education for isolated families, especially services that meet clients where they are at or in places they frequently go.
- Mental health literature in Armenian, a waiting room brochure, for example, containing information on how to recognize early warning signs.
- Substance use, physical abuse, and gang involvement education to parents, providers, and law enforcement.
- Cultural sensitivity and competency training for elementary school teachers and law enforcement officers.

Specific Strategies and Approaches to Service Delivery

- Expansion of programs/services with a demonstrated record of success.
- Learn from faith-based and other education models that address the entire family not solely the individual, and expand their services, perspective, and framing.
- Community organizing events and fairs that promote community bonding and cohesion, including being a member of a women's group, fraternities, and extended families.
- PTA/PTOs and community organizations to provide services to meet families' needs in a non-threatening way, providing food and/or therapeutic child care as needed.
- Better training of Armenian Youth Federation workers.

Funding and Resources

- Consistent funding of existing programs.
- More funding for current Family Preservation services for families. In 2002, 38,000 children were in care. There are now 22,000 in care, so family preservation programs are working but need greater investment to ensure success.

Other

- Greater collaboration among service providers.
- Recruitment, employment, and maintenance of qualified staff and consistent personnel.

Priority Early Intervention Services/Resources (Q6b)

When three of the six focus groups were asked to prioritize the needed early intervention services they had cited in response to the prior question, they selected three priority services, as shown in **Table 7**. Two of the six focus groups represented pilot sites and were not asked by focus group facilitators to prioritize early intervention services, the third focus group was unable to prioritize their list of services. The priorities identified by three of the six groups reflect early intervention services that would:

- Train providers across sectors to identify warning signs;
- Provide psychiatric identification and evaluation;
- Conduct outreach to underserved populations;
- Expand funding for family-centered treatment services; and,
- Involve PTAs and/or PTOs in service provision.

Table 7: Priority Early Intervention Services/Resources (n=3)*

Focus Group	Priority 1	Priority 2	Priority 3
Armenian Relief Society	Training around warning signs.	Outreach and support for LGBTQ, special education, and newcomers to the community.	Mass media.
San Fernando/Santa Clarita Child Abuse Prevention Council	More emergency psychiatric care facilities for children and adolescents.	Specialized Psychiatric Evaluation Teams for children.	Expanded funding for current services for families.
Valley Care Consortium Committee, Mental Health Subcommittee	Community-based programs that provide treatment for and collaborate with families, and use parents as a resource.	PTAs and/or PTOs and community organizations to provide services to meet families' needs in a non-threatening way, providing food and/or therapeutic child care as needed.	Services for teen mothers.

Note: Priorities not listed in rank order

“All the proof is in Prevention and Early Intervention and they’re the least dollars spent, and they have the most bang for your buck. So, really, again, I can’t stress the importance of the low cost, the on-going, existing Early Intervention Programs ...without even recreating the wheel, just funding what’s out there.”

Locations for Early Intervention Services/Resources (Q6c)

Table 8 presents the locations at which focus groups would like to see early intervention services offered. Two of six focus groups responded to this question. The participants of those focus groups suggested locating services at schools, churches and/or synagogues, community centers, hospitals, libraries, parks, and primary care physicians' offices. Other locations offered can be found in the table below.

“Places where mothers or parents might be where you have possible at-risk kids. That could be health centers ... boys or girls clubs ... churches or synagogues ... substance abuse programs.”

Table 8: Early Intervention Service Locations

Early Intervention Service Locations	Number of Groups (n=2)*
Schools	2
Churches/Synagogues	2
Community Centers	2
Hospitals	2
Libraries	2
Parks and Recreation Centers	2
Primary Care Physician Offices	2
Agencies that have Promotoras	1
Boys and Girls Clubs	1
Community-based programs	1
Community Health Clinics	1
Factories	1
Homeless Shelters	1
Homes	1
Laundromats	1
Probation Camps	1
Restaurants	1
Substance Abuse Programs	1
Supermarkets	1
Work sites	1

* Four focus groups did not provide preferred locations for early intervention services

VIII. Barriers to Service Access and Strategies to Increase Access

Barriers to Service Access (Q7)

Focus group participants were asked “What keeps people from getting the prevention and/or early intervention services they need?” In response, Service Area 2 focus group participants focused largely on various access issues. **Table 9** shows that participants mentioned service costs, transportation and geographic isolation, stigma, cultural competency, service operations, and service availability as key barriers to service access.

Access issues surrounding costs, insurance, and eligibility issues focused on the time commitment and economic pressures people experience accessing services, especially when insurance as well as service costs are high and/or the eligibility criteria are too strict, and/or if childcare is not available or

if families incur additional costs to secure childcare in order to receive treatment themselves or for other children in the family. Participants also underscored the fears associated with the stigma and shame of seeking help from a mental health service provider. Some talked about being labeled “crazy” or being ostracized within their communities after seeking help. A few participants pointed out that once people access treatment services, the lack of cultural and linguistic competency among service provider staff often results in a non-personalized and non-consumer-oriented experience that further discourages consumers from seeking treatment. Overall, the inability of consumers to access needed services erodes their trust in the system of service provision altogether.

Two additional areas that were mentioned concerned the lack of education and awareness about mental health among community members as well as the lack of parental support or engagement in children’s mental health needs. Focus group participants noted that community members not only lack awareness about existing mental health services, but also lack awareness of alternative community support systems, such as the faith-based communities, that might be able to assist them in meeting their mental health needs. Other participants stressed that community members’, in particular families’, lack of awareness is not limited to what services are available, but extends to a lack of recognition that mental health services may be necessary, and/or a disinterest in engaging in services once the mental health needs have been identified. One participant commented that often consumers lack support within their own families, sometimes due to the patriarchal structure and control of the family, which denies family members access to services. Another participant stated that families often do not understand the potential benefits of engaging in mental health services; and, other participants suggested that denial plays a large part, as does the consumer’s personal motivation to access services in the first place.

Other barriers cited included the following:

- The lack of an ongoing continuum of care;
- A lack of connectivity between service providers and agencies across sectors;
- Inconsistencies in the quality of services delivered;
- Inadequate assessments, ignored symptoms, or misdiagnoses by professionals;
- Homelessness;
- Poor staff retention among service providers;
- Financial hardships of community-based organizations;
- Inability to cross neighboring gang turfs to receive services;
- Safety issues for providers traveling into dangerous communities; and,
- Lack of direct access to medical doctors and psychiatrists.

“I’ve really realized that there are lots of really good services out there, but there’s just something about the system that does not connect the dots. Though, I don’t think that we utilize ourselves and work together. We need to collaborate more.”

Table 9: Barriers to Service Access

Access Barriers	Number of Mentions
Access Issues	23
• Cost/Insurance/Medi-Cal/Eligibility Criteria	6
• Stigma	5
• Geographic Locations/Transportation	4
• Service Linguistic/Cultural Competency	3
• Service Operations	3
• Available Services/Capacity	1
• General Service Access	1
Outreach/Education/Awareness	5
• Available Services	3
• General	2
Service Engagement/Benefits	5
Service Integration/Continuity of Care	2
Service Quality	2
Funding and Resources	1
Immigration and Cultural Matters	1
Social/Economic Conditions	1
Staff	1
Provider/Education/Training/Recruiting	1
Trust	1
Other	6

Strategies to Increase Access (Q8)

As a follow-up to the question about service barriers, focus group participants were asked to discuss the types of strategies that would help people obtain access to the services they needed (see **Table 10**). A number of strategies and approaches to improve service access were identified and covered a range of areas. Some strategies pertained to the process by which PEI services would be decided and provided, such as prioritizing the areas of focus for PEI services so that access is not diluted; keeping the PEI process SAAC focused; allowing each Service Area involvement in the decision-making and implementation of services as a means of improving access in the communities served; establishing a steering committee to make the PEI plan practical and effective; being transparent by providing information about the process and outcomes; and, offering a comprehensive menu of consumer-friendly services without the label of “mental health.”

Other specific strategies for increasing service access included:

- 1-800 numbers for people to call and request mental health services;
- A directory of existing services;
- Community courts where homeless persons who are mentally ill can receive counseling;
- Services for older adults;
- Resource personnel in each DCFS office to help build connections between departments and community partners; and,
- Rebuilding and tightening the community safety net.

Following specific strategies and approaches was an emphasis on using outreach, education, and awareness as a means to improve access. Given that any one of us can be “at-risk” of mental illness at any given time in our lives, participants in one focus group voiced the need for stigma-reducing

public awareness and outreach campaigns that promote wellness as “everyone’s responsibility.” From this perspective, outreach and education would serve as a means of reducing the current level of public apathy toward those who suffer from mental illness.

“One-third of the population in Glendale is Armenian, but there are very few practitioners, and the non-Armenian practitioners don’t have language appropriate information or literature.”

To focus group participants, improving access also means removing access barriers such as costs, transportation, and the cultural and linguistic competency of services. Participants expressed the need to make services geographically accessible by locating them within communities and neighborhoods with satellite offices and by subsidizing transportation.

Participants identified a few specific services they felt would improve access. Two of these services work to engage the homeless populations. One recommendation was to have mobile units go to homeless encampments, particularly those with children; and the other recommendation was to promote Projects

for Assistance in Transition from homelessness. Another specific service mentioned by one of the participants was to expand in-home family services and provide in-home parenting technical assistance. One participant also suggested supporting more TTY telephone capability.

Furthermore, participants from two focus groups identified a few location-based services that make services more accessible for community members. For example, someone suggested placing services close to bus stops and other public transportation terminals. Other examples included small satellite office resource centers, and multi-service one-stop family service centers, potentially located at schools, with a reference desk for referring people to appropriate services.

Table 10: Strategies to Increase Access

Strategies to Increase Access	Number of Mentions
Specific Strategies/Approaches	14
Outreach/Education/Awareness	10
• General	4
• Specific Mediums	3
• Specific Locations	1
• Linguistic/Culturally Appropriate Messaging	1
• Messaging	1
Specific Services	5
Access Issues	5
• Geographic Location/Transportation	2
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1
• Service Linguistic/Cultural Competency	1
• General Service Access	1
Location-based Services	4
Collaboration/Partnerships/Teams	1
Service Integration/Continuity of Care	1
Staff/Provider Education/Training/Recruiting	1

IX. Recommendations for Informing Communities about PEI

Recommendations

When focus group participants were asked to provide recommendations on how to let people know about prevention and early intervention services, they overwhelmingly underscored the importance of outreach, education, and awareness (see **Table 11**). Ways of conveying information about prevention and early intervention mental health services were heavily discussed and centered on a variety of mediums. Aside from the typical forms of messaging such as media advertising, newspapers, radios, cable television, the Internet, flyers, and word of mouth, participants recommended the following less conventional means of outreach:

- Inserting mailers into utility bills and/or children's school bags;
- Engaging politicians and consulates to advocate for increased services;
- Using the Promotoras model to penetrate deep into communities; and,
- Reaching community members through grassroots outreach and education.

"You have to use multiple media. You can't reach everyone through one media. Flyers work for some people, radio for the Latino population."

Specific locations at which outreach could be conducted ranged from festivals to beauty salons, health fairs, banks, and supermarkets -- all locations people typically frequent. One participant also suggested utilizing SAAC meetings as a vehicle for providing updates and information to the general public about the myriad services and programs available throughout Los Angeles County.

As participants brainstormed the mediums for and specific locations at which outreach might take place, they also talked about how the message should be expressed. A couple of participants pointed to providing information visually, rather than in words, and to keeping the message simple, direct, and to the point.

As part of these recommended outreach efforts, participants also discussed the types of education community members need. In particular, participants stated that parents could benefit from leadership training, and that families need to be educated on the early signs or symptoms of mental illness and become familiar with available services and supports. In addition to families, participants in one focus group recommended extending education about PEI to DCFS staff and the staff at other agencies.

"I think it comes back to our training piece. The internal problem with DCFS would be the training piece with the new workers, you know, in the academy to let them know how to access community resources. Because as a new worker, even as a worker who's been there, you're so overwhelmed with all the policy changes..."

Specific strategies and approaches mentioned to inform communities about PEI included the following:

- Connecting with local agencies that have external, government relations to promote successful programs;
- Mobile units that can travel to each community to educate folks on health and mental health issues; and

"Resource awareness is critical. We're doing a bad job letting people know what's out there. No one knows to call 211."

- Promotion of 211 to raise awareness about existing resources.
- Start in “small pockets” in each area , working with advocates and community entities such as PTAs, faith-based organizations, schools, health or medical clinics, and parent resource centers to disseminate information.
- Utilize pre-existing community councils, such as the Los Angeles County Children’s Planning Council’s Service Planning Area 2 Council. This council is engaging community members to take leadership in meetings, form groups, and support groups in taking action. This strategy has a positive impact on promoting healthy children and families.

“The most successful programs are programs that start in one small geographical area, prove themselves, and then grow. And if you’re going to spread everything out to the point where it’s diluted, you’re not going to see the success. So, you need to do pockets, and then, grow from your pockets.”

Other recommendations for informing communities were:

- More mental health practitioners and professionals;
- Consistent, broad, and integrated outreach, especially for programs already in existence; and,
- Funding and resources to increase outreach activities for PEI.

Table 11: Recommendations for Informing Communities about PEI

Recommendations	Number of Mentions
Outreach/Education/Awareness	40
• Specific Mediums	21
• Specific Locations	8
• General	3
• Messaging	3
• Available Services	2
• Linguistic/Culturally Appropriate Messaging	1
• Families/Parents	1
• Specific Outreach	1
Specific Strategies/Approaches	6
Service Integration/Continuity of Care	1
Staff /Provider Education/Training/ Recruiting	1

X. Summary

The Service Area 2 focus groups represented 44 participants from six diverse agencies with broad representation in the community. Of those 44 participants, 80 percent identified Trauma-exposed individuals as a top priority population; and, across the six focus groups participants identified Disparities in access to mental health services a priority mental health need. Correspondingly, priority prevention services focused on increasing awareness, training culturally and linguistically appropriate providers, promoting collaborations and partnerships, providing family centered services, and expanding youth groups and counseling services. Similarly, priority early intervention services emphasized outreach and training, psychiatric services for children and adolescents, and family

oriented community-based programs. Among the access barriers cited by participants, issues such as costs, lack of insurance, and eligibility criteria received higher mentions than other access barriers. In response, participants cited a number of strategies to address access directly, some of which focused on the process by which PEI would be decided and provided. Finally, the focus group participants overwhelmingly underscored the importance of outreach, education, and awareness as a means of reducing apathy and/or stigma toward those who have a mental illness.

APPENDIX A

APPENDIX A: Focus Group Guide

FOCUS GROUP QUESTIONS

Issues	Focus Group Questions
<i>PEI Planning Process</i>	<ol style="list-style-type: none"> 1. Have you or your group taken part in the Los Angeles County Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) planning process? If so, how?
<i>Participants' Organizational Affiliation</i>	<p>These focus groups help us learn more about the types of mental health services and resources that are needed to support the social and emotional well-being in your community and among other groups of people in L.A. County.</p> <ol style="list-style-type: none"> 2. Which region or area in L.A. County do you represent or will you be talking about in today's discussion? <ol style="list-style-type: none"> 2a. Of the identified priority populations [<i>facilitator refers/points to visual aid listing priority populations</i>], which of these groups of people do you represent?
<i>Community Mental Health Needs</i>	<p>The California State Department of Mental Health said that the Prevention and Early Intervention (PEI) plan should focus on the needs of the following groups: at-risk youth, people who may be at risk of suicide, people who haven't been able to get services, and people who have experienced trauma, stigma and discrimination.</p> <ol style="list-style-type: none"> 3. What needs are most important to the group of people you represent? <ol style="list-style-type: none"> 3a. <i>Of the needs that you've listed, which are the top three needs most important to your community?</i> 4. What do you see happening in your community because of these needs? (what problems are occurring?)
<i>Prevention and Early Intervention Services</i>	<p>As we talked about earlier, there is a difference between prevention and early intervention services [<i>facilitator refers/points to visual aid defining prevention and early intervention</i>].</p> <ol style="list-style-type: none"> 5. What prevention services or resources are currently available in your community or among the group of people you represent? <ol style="list-style-type: none"> 5a. What prevention services or resources are needed? 5b. <i>"Of the prevention services you've listed, which are the top three needed."</i> 5c. <i>Facilitator probes for information on locations for services.</i>

APPENDIX A: Focus Group Guide

Issues

Focus Group Questions

-
6. What **early intervention** services or resources are currently available in your community or among the group of people you represent?
 - 6a. What **early intervention** services or resources are needed?
 - 6b. *Of the early intervention services you've listed, which are the top three needed in your community?*
 - 6c. *Facilitator probes for information on locations for services.*
 7. What keeps people from getting the prevention and/or early intervention services they need?
 8. What types of things or strategies would help people get the services they need?

*Long Range
Planning*

9. What recommendations do you have for how to let people know about prevention and early intervention services?
-